ANNIE TEMPLE, LCSW

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Authorization for Release of Protected Health Information

CLIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ / _____ / _____ Email: _____

Phone (*check preferred*): ☐ Mobile: _____ ☐ Home: _____

Mailing Address: _____

Who may RECEIVE the information?	**Who may DISCLOSE the information?**
☐ Annie Temple, LCSW CA License #75266 801 Alhambra Blvd., Suite 1 Sacramento, CA 95816	☐ Annie Temple, LCSW CA License #75266 801 Alhambra Blvd., Suite 1 Sacramento, CA 95816
☐ _____ (*Name of person or facility to receive information*)	☐ _____ (*Name of person or facility with information*)
_____ (*Street Address*)	_____ (*Street Address*)
_____ (*City, State, Zip Code*)	_____ (*City, State, Zip Code*)
_____ (*Phone Number*)	_____ (*Phone Number*)

PROTECTED HEALTH INFORMATION TO BE RELEASED

Check ONE:

☐ All protected health information

☐ Only the following protected health information or types of information: _____

_____

☐ Psychotherapy notes ONLY (*If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.*)

PURPOSE OF RELEASE

Check all that apply:

- ☐ Mental health care
- ☐ Application for insurance
- ☐ Legal investigation
- ☐ My personal request
- ☐ Other: _____
- ☐ Insurance claim
- ☐ Employment
- ☐ Disability determination
- ☐ Rehabilitation services

TERM OF RELEASE

This authorization will expire on the following (check ONE):

☐ Specific date: _____ / _____ / _____

☐ Upon the happening of the following event: _____

AUTHORIZATION AND SIGNATURE

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signature of Client: _____ Date: _____

OR

Signature of Personal Representative: _____

Print Full Name: _____ Date: _____

Relationship to Client: _____